Report to the Health Insurance for Indiana Families (HIIF)

What people are saying about the care they receive, the care they provide, the care they pay for, and the care they insure.

Feedback from Focus Groups

October 1, 2003

HealthEvolutions
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Outline/Table of Contents

Introduction/Background

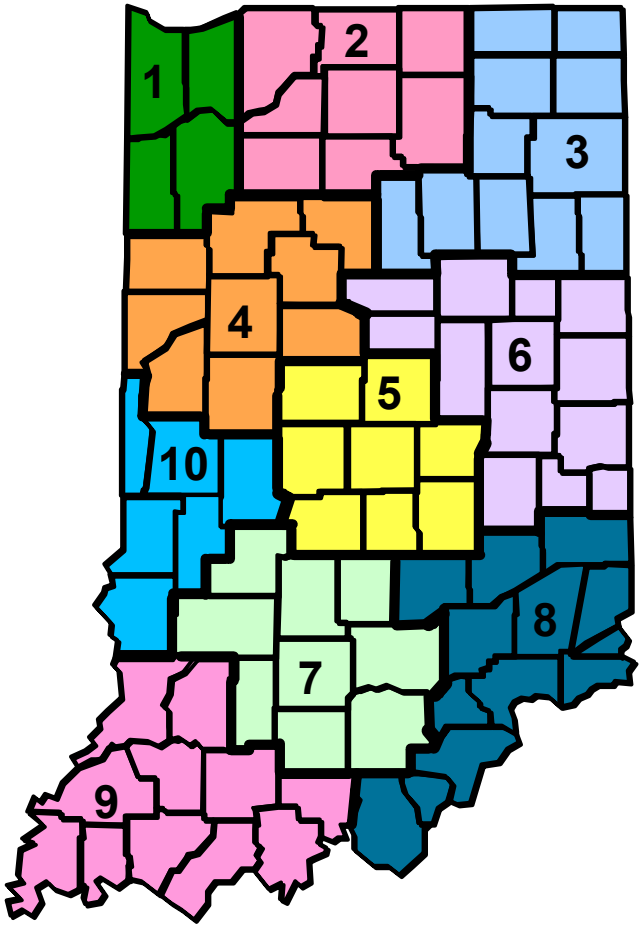
Who did we talk to and what did they say?

Stakeholder groups that were identified included:

- Uninsured and under-insured people
- Providers including physicians and hospital leadership
- Business owners both large and small
- Insurance brokers
- Community groups of interested stakeholders

Where do these people live?

- The state was divided into ten regions and we had conversations with major stakeholder groups in each region



How many people did we talk to?

We talked to over 340 people:

- There were over 165 consumers
- There were over 37 insurance brokers
- There were over 43 providers including hospital leaders, community mental health center directors, and physicians
- There were 22 business leaders
- There were over 76 people who participate in community groups who are working to improve healthcare access in their hometowns

How did we recruit these people?

- Between May and September we had 40 meetings with people who were recruited by:
  - The Indiana Health and Hospital Association
  - The Indiana Chapter of the National Federation of Small Business
  - The Indiana State Chamber of Commerce
  - The Indiana State Medical Association and local medical societies
  - Step Ahead Councils
  - The Indiana Brokers Association

What questions did we ask them?

	Consumers	Providers	Community Groups	Brokers	Businesses
On the Uninsured		X	X		
On Coverage	X	X	X	X	X
On Costs	X		X	X	X
On the Consequences	X	X	X		X
On Concerns of Businesses				X	X
On the Basic Plan	X	X	X		
On where to receive care	X	X	X		
On Changes				X	X
On the health care experience	X				
On Government Programs	X	X	X		X
On Responsibility for Coverage	X	X	X	X	X
On the future	X	X	X	X	X

On Variations

Our conversations revealed that there were both similarities and differences between stakeholders from region to region. The differences can most often be characterized by three defining characteristics that drive either supply or demand of healthcare services. These characteristics include:

- Economic drivers
- Demographic changes
- Changes in the healthcare market including the availability of safety net services

All of these have a direct impact on the number of uninsured and the availability of healthcare services in communities across Indiana.

Community Drivers

- **Lake and Porter Counties** – This area has been greatly affected by the downsizing and closing of the steel plants. This has left many people without jobs, without insurance, and without many options. Because of the age of many of these people, they don't believe they can start over. Even with the insurance support from the state, they are still faced with no family coverage for their spouses.
- **Lake County** – There have been changes in the hospital market in Lake County. With the sale and/or consolidation of the Ancilla Hospitals, the cost pressures have been significantly increased for Gary Methodist and St. Catherine's Hospitals. In addition, while this region has always had a diverse base, there has been an significant increase in the Hispanic population, putting more stress on the healthcare system.
- **Allen County** – There are many people who are without insurance because of the closing of Tokheim, Dana Corporation, and the downsizing of Lincoln Life. These are individuals who had very good comprehensive insurance and are coming to the end of their COBRA option.
- **Clark and Jefferson Counties** – These counties appear to be well served by a clinic system that has four clinic sites. Funded originally through a community focus fund grant from the Department of Commerce, it is now supported by the hospital, volunteer physicians, and general community contributions.

Community Drivers

- **Jasper County** – Since late 1999, the mega-dairy farms have hired large numbers of Hispanics to work. This has increased the demand on the area healthcare providers. One support system for pregnant women is through the Birthright Program in Rensselaer which supports primary and prenatal services for uninsured pregnant women.
- **Davies County** – A nurse managed clinic in Washington, Indiana, fills a significant gap in provider availability.
- **Decatur County** – A free clinic in Greensburg which was originally funded through a MCH grant and is now supported through donations and volunteer physicians. There are, however, long wait times to get an appointment.
- **Vigo County** – St. Anne's Clinic provides most of the safety net care in Terre Haute but is only open two days per week.
- **Clinton County** – The county is still largely a farming community. Many are insured through the public sector where one family member can get coverage for everyone in the family.

Community Drivers

- **Vanderburgh County** (Evansville) – Uninsured population includes many temporary and part-time workers and most do not qualify for health insurance, and those few that do cannot afford premiums. A free clinic is available but some physicians are avoided.
- **Boone County** (Lebanon) – Predominantly rural and suburban community with a free clinic that is very popular and well utilized with uninsured residents. A nurse practitioner at the clinic provides a consistent image and source of help/navigation for the local healthcare system.
- **Steuben County** (Angola) – A predominantly rural community with many senior residents who are uninsured. Pride and stigma attached to pubic assistance prevent many who may qualify from applying for Medicaid. However, those on Medicaid have trouble accessing physicians since many local physicians do not participate in the program. Weak local economy and a lack of employment opportunities make qualifying for Medicaid a primary focus for many younger residents.
- **Owen County** (Spencer) – Lots of small companies offering unaffordable health insurance results in relatively large uninsured population. While the local ER attracts many, the local head start clinic assists many uninsured with their clinical needs and navigation to other providers including other social service agencies. Awareness and coordination across several state programs is enhanced with the head start clinic being housed in the same complex as other state agencies.

Community Drivers

- **Hancock County** (Greenfield) – There is a significant amount of small business employees and self-employed individuals within this relatively healthy regional economy. Most of these cannot afford adequate coverage thereby creating a sizable uninsured/underinsured population. No free clinic is available which forces those without coverage to access the ER for urgent care and the financial hardship that follows. Access to specialist care is difficult as up front deposits for procedures are unaffordable.
- **Howard County** (Kokomo) – Many local residents have been affected by recent layoffs from the large automotive manufacturers. A safety net for the uninsured is dominated by the Catholic hospital-sponsored free clinic. The clinic is very popular with a quality reputation but timely access for appointments and specialist physicians is difficult due to heavy patient volumes against a short supply of volunteer physicians. Therefore, the two local hospital ERs experience steady demand from this population.

Findings

Findings

The questions asked in each of the focus groups covered six broad categories.

These categories included:

- Coverage
- Costs
- Consequences of not having insurance
- What should be in a basic plan
- How is the safety net system working or not working
- What is the perception of how the government programs are working and, when possible, the groups were asked for suggestions on how to increase coverage

The following slides detail the major findings in each of these broad categories.

Findings (cont.)

Coverage

- As the Indiana manufacturing-based economy continues to decline, many large businesses have reduced their workforce or closed. As a result, these employees are forced to find work with much smaller businesses, are faced with much higher rates, and are more likely to not accept coverage.
- The growing number of Hispanics in all parts of the state contribute to the growing number of uninsured.
- Most small employers are shifting the increased costs of healthcare coverage to the employee in the form of higher co-pays, higher deductibles, spousal exclusion, and overall reduction in the benefit level in order to keep premium increases more manageable over time.

Findings (cont.)

Costs

- By a large margin, the high cost of healthcare insurance is the number one obstacle to increasing coverage through both the employer and individual markets.
- The economic downturn has greatly exacerbated the importance of cost as the main factor in acquiring healthcare insurance coverage. Businesses that are still offering health insurance are passing the costs on to their employees.
- An economic rebound will greatly help decrease the numbers of the uninsured by making coverage more affordable relative to revenue/income levels, but due to the way healthcare is insured, sold, and utilized, cost will remain the key factor.
- The presence of employer-based insurance coverage among small businesses is rapidly shrinking because it is unaffordable for both employers to offer and the employees to purchase.
- Small business premiums are extremely volatile since each small group must spread the expected cost of its high risk cases across a small pool of employees.
- While health insurance may be available to employees, many employees in small businesses choose not to accept/purchase coverage due to its very high cost.
- Premium cost, rate stability, claims service, and provider network are the primary key criteria to customer satisfaction with a health plan.

Findings (cont.)

Consequences

- Many Hispanics do not seek care for certain conditions for cultural reasons and fear of governmental scrutiny. They also typically work in the kinds of positions that either don't offer insurance or offer very expensive insurance.
- The true cost of health insurance is measured in monthly premium cost plus any co-pays and deductibles. Small business employees with insurance coverage are faced with significant co-pays especially for physician office visits, prescription drugs, and laboratory tests. As a result, many uninsured choose to not fill costly prescriptions and do not receive the care they need.

What should be in a basic plan

- Uninsured individuals are willing to pay something out of their pocket for health insurance coverage. While the range of acceptable monthly premium payments is large, all agree that any "basic" health plan must adjust its premium based on income level through a "sliding scale."
- Most people believe a basic plan should cover primary and preventive care first, there is considerable concern over catastrophic expenses that could be incurred.

Findings (cont.)

How is the safety net system working or not working?

- Very few of the county "safety net" systems are well-organized. Only a few of these are organized and able to inform and administer several state programs effectively. Of these, only a handful have demonstrated they are proactive enough in securing grant money to improve healthcare service delivery. There is also no system to coordinate their efforts or document and share best practices.
- The availability and utilization of the "safety net" to address the healthcare needs of the uninsured varies greatly from county to county and, therefore, from region to region. Even the best safety net system has gaps in coverage either because of long wait times or the availability of comprehensive services.
- The uninsured are very reliant upon their local hospital ER, and any free clinics that may exist in the area, for their primary care needs. Without a free clinic in the county, the uninsured are very reluctant to seek care due to the threat of personal bankruptcy or damage to their credit record.
- The presence of free clinics varies by county and most cannot serve all of the primary care needs of the uninsured in a timely fashion (long waiting times for appointments, only open a limited number of days).
- The uninsured are finding it difficult to access primary care since appointments are given on the basis of whether one has insurance or not. Access to specialist based care is virtually impossible since specialist physicians demand that 100% of the procedure's cost be paid prior to service.
- Providers opt out of the Medicaid system because of the perceived or real cost of treating "non-compliant" patients.

Findings (cont.)

Government Programs

- Due to its complex nature, broad government insurance programs like Medicaid are not well understood by staff, enrollees, and many providers.
- There seems to be a lack of any external communication effort in order to publicize the existence of state public health programs to potential enrollees.
- Medicaid is perceived as a very slow and very complex system. Most of the uninsured cannot understand why eligibility decisions take between six months to over a year in some cases. It would appear the system's complexity prevents many state employees from informing recipients of other state programs they may qualify for. Providers opt out of the Medicaid system due to inadequate reimbursement and the costly and time consuming process of Medicaid auditing.
- Medicaid's rich benefit package and first dollar coverage creates a large disincentive for those on Medicaid to find work since their health coverage would diminish as a result of working for a small employer.
- Many of the uninsured populations lack awareness of the many state benefit programs that may be available to them.

Findings (cont.)

Recommendations for increasing coverage

- There is considerable support for a state funded health benefit plan for the uninsured with a focus on primary and preventative care. There are some stakeholders, including the uninsured, who would pay for their primary care but want protection from catastrophic healthcare expenses.
- The supply of physicians to free clinics for the uninsured would be enhanced by the state's efforts to assist them with liability and malpractice protection given the higher medical risk and litigious nature of this population in general.
- There is recognition by all stakeholders that the problems of the uninsured is great but there is little consensus between the groups on either short-term or long-term options.

Emergent Themes by Stakeholder

Emergent Themes - Uninsured

- Cost is the number one obstacle to purchasing insurance (impinges on other important spending) .

One woman in Region 6 was a CNA working at a local nursing home. The cost for family coverage for her would have been approximately $500 per month out of her estimated $16,000 annual salary or $1,300 per month before taxes.

- Many do not qualify for the opportunity to purchase insurance coverage due to pre-existing conditions.

One woman in Region 4 was rejected for insurance coverage because of a previous bout with depression. She felt betrayed by a system that on the one hand encouraged her to get help but turned around and punished her for doing so. She was young and very nervous about the increased stress of not having insurance if she needed it.

- While temporary and part-time work is available, the workers rarely, if ever qualify for health insurance.

- Most of the uninsured believe that "Healthcare is a right – not a privilege" and are desperate for solutions.

One woman in Region 10 was almost at the end of her transitional Medicaid assistance benefit. She was working for a daycare center where no insurance was offered. She had Type 1 diabetes and was dependent on insulin. When asked what she was going to do when her Medicaid benefits ran out, she simply said, "I don't know."

- Access to quality care (appointments and specialists) often requires coverage or 100% payment in advance.

One woman in Region 7 was denied access for her sick child because she owed money on a previous bill.

Emergent Themes - Uninsured (cont.)

- Medicaid is a "cadillac" benefit plan that is difficult to qualify for, sought by many, and disincentivizes many from wanting the relatively poor insurance coverage that comes with a job.

One woman in Region 8 said she knew she could get a job, lose her Medicaid benefits, pay someone more than she would make to care for her invalid husband and disabled child but she made an economic and personal decision that she could give better care and be better off herself. Therefore, she is not working and qualifies for Medicaid.

- Free clinics, if locally available, are heavily utilized.

- Fear of bankruptcy/additional debt/bad credit dissuades many from accessing care – especially the ER. Few, if any, indicated they used the ER as a preferred source of care. Because they knew the financial consequences, they went as a last resort.

One woman in Region 8 had bills over $500,000 of mostly hospital debt and knew she would never be able to pay it off.

- Hoosier Healthwise is wonderful for the kids – but parents have to go without.

One woman in Region 4 left her teaching position with good health insurance to care for her children one of whom had a physical disability. Her husband works construction and does not have access to any insurance coverage. The children were eligible for Hoosier Healthwise but the parents were left without any coverage.

Emergent Themes - Uninsured (cont.)

- Preventative care (i.e., screenings), vision, and dental are the most sought after benefits in insurance plans. Prescription drugs are also a great need but once inside the safety net system, many are able to access prescription drugs through office samples or one of the Pharma programs.

  One man in Region 5 chose to participate in a clinical trial program in order to gain access to his medications.

- The uninsured are willing to spend money on the "right" health plan. Generally speaking, the uninsured expressed willingness to pay anywhere from $150 to $500 per month for the security and protection they would have with insurance.

- The uninsured believe that the government, the employer, and the individual all have a role in addressing the uninsured issue but the government must lead the effort.

Emergent Themes - Providers

- Coverage is not available to the unemployed, the employees of small businesses, and/or those earning minimum wage.
- Several physicians agreed that "Access to healthcare is a right – access to health insurance is not a right."
- Primary and preventative care will prevent the uninsured from flooding ERs, but educating this population is a crucial prerequisite.
- The Medicaid agency is perceived as a slow, bureaucratic system that dissuades many physicians from participation by virtue of very low reimbursement levels, lots of paperwork, and an overall "hassle" factor – which does not bode well for the success of any potential state-sponsored health plan.
- The Medicaid health insurance benefit is extremely benefit rich thereby incentivizing its recipients inappropriate utilization of healthcare resources.
- Insurance coverage should be mandatory for individuals to carry.
- Prescription drugs are extremely unattainable for the uninsured due to their out-of-pocket costs.
- Physicians would be willing to donate more time to serving the uninsured if the overall reimbursement levels were higher and the state would assist with liability and malpractice insurance coverage.
- Free clinics are being used – but having little effect on reducing ER volumes.

Emergent Themes - Community Groups

- Cost is the #1 issue to acquiring coverage.

- Not all community healthcare safety nets are alike – some are better than others.

  One woman in Region 8 was in desperate need of mental health counseling. She was working in a bakery and was waiting for her insurance coverage to begin in six months. She recently had family difficulties after one of her sons was shot by another son. When she called to get counseling help, she was told she would have to wait two months for an appointment. The safety net clinic was able to assist her in getting an appointment.

- Not all funding mechanisms for the safety nets are alike – some communities are better at accessing grants than others.

  The safety net clinic in Region 5 sees about the same number of patients but they are in greater need of accessing prescription drugs.

- Personal pride and social stigma of public assistance prevents many in rural areas (particularly seniors) from seeking public assistance.

  Many respondents told of grandparents raising their grandchildren and not knowing how to access care.

Emergent Themes - Community Groups

- General awareness of state programs varies by county and community and their communication is dependent upon word of mouth. Many nurses and doctors do not know about safety net programs and are unable to assist patients in accessing these programs.
- Hispanics have cultural biases on seeking care and some communities are much more proactive on outreach than others. Language is only one barrier to seeking care.
- The safety net system helps provide primary care but does not help with specialty care. For example, the person may come into the ER with chest pains but the patient will not get free care for a coronary bypass.

Emergent Themes - Brokers

- Healthcare insurance and coverage is a privilege – not necessarily a right

- Cost is the #1 criteria in an employer's decision to offer coverage.

  One broker described what happens when he delivers the renewal quotes. "The owner's eyes go directly to the bottom line and they work backward to the benefits. They love the service but hate the rates."

- In small businesses, the decision to whether to offer coverage is very owner dependent and is often a decision on gaining personal coverage.

  If the spouse of the owner has insurance, he or she is less likely to offer insurance to the employees.

- While HIPAA has increased the complexity and cost of administering health insurance by 10-15%, it has helped to police fraud in employer information disclosure

- Cost shifting is alive and well (whether from employer to employee, from employee to spouse's employer, etc.).

- Insurance carriers often under price to land the new employer account, then raise rates in the following years to compensate for losses in the early years.

Emergent themes - Brokers (cont.)

- Benefit mandates from the state add significant cost to the cost of group insurance
- The absence of significant condition waiver legislation from the state diminishes the market for affordable coverage options for individuals.

The brokers were very clear about the deterrent to expand coverage that this caused.

- Tax credits may be a good incentive for individuals to purchase insurance.
- There needs to be a significant focus on lifestyle choices.

Many brokers were outspoken about people choosing to make material purchases before buying health insurance. They also expressed concern about lifestyle choices that make the need for future healthcare services inevitable.

Emergent Themes - Small Business

- Skyrocketing cost of health insurance is the #1 issue to increasing coverage.
- Ability to offer coverage is directly tied to the health of the overall economy.
- Yearly premium rate increases of 25-30% are common.
- Employees perceived as "high risk" can send premiums up 75-100% the following year.
- Employers are utilizing any and all cost-shifting strategies toward employees with many employers moving toward defined contribution.
- Several employers have joined Professional Employment Organizations (PEOs) in order to purchase coverage at discounted rates - with varying success.
- Awareness of state programs which employees may qualify for is virtually non-existent.
- Very skeptical of any government sponsored initiatives to address the uninsured (i.e., state health plan).
- Employees (and employers) need to become better consumers of healthcare – but the lack of any comparative information makes this difficult.
- Employer tax credits for offering coverage are viable if the benefit is prorated based on the level of coverage offered.

Summary

Summary

- The skyrocketing rise in healthcare costs directly affects small business as small business premium cost trends have averaged 20-30% per year and sometimes reach 100% depending on specific individual risks.
- Small businesses require additional financial incentives to offer coverage such as tax credits.
- The state should investigate the feasibility of sponsoring a state basic health plan that the uninsured can buy into regardless of income level. Such a plan should focus on preventative care and primary care in order to replace the ER as the preferred care setting. Premium and co-pays should be based on a sliding scale based on income.
- The state should investigate how it could assist physicians with liability and malpractice protection as an added incentive for them to staff free clinics in order to further reduce the ER demand.
- Free clinics should be available in every county and promoted with effective communications programs.
- The state should explore the impact of its coverage mandates that require insurance companies to cover certain conditions in order to spur the development of lower cost insurance products into the individual and small business group insurance markets.
- State benefit mandates affect premiums of small businesses insurance products disproportionately since large businesses are likely self-insured and likely exempt from state regulations through the ERISA exemption.
- The Medicaid benefit package needs to be restructured in such a way that its recipients are incentivized to look for work and the improved health insurance benefits that usually accompany a job. The ticket to work should be expanded.

Sample Vignettes
from the Uninsured Focus Groups

Uninsured Healthcare - Individual Experiences

- A woman in her late 50s spends her time taking care of her sick mother, who is on Social Security. She cannot get medical coverage, and is afraid to apply for Medicaid for fear of losing her home so she utilizes the free clinic.
- A middle aged man who takes care of his mom, who is disabled, cannot get physician care without providing money up front for care. She is need of specialty diagnostic and treatment procedures which require 100% payment in advance before the physician will treat her. In order to get his routine care, he goes to the free clinic and utilizes prescription cards from the major companies to obtain medications.
- A middle aged male who manages a new life recovery home has diabetes and cannot obtain affordable medical coverage, so he regularly visits the free clinic as do many of the men living in his home. He notes how Indiana public health programs help women and children, but that it is difficult for men to qualify for public healthcare programs.
- A woman in Dekalb County described losing her benefits after the premiums went up 250% in one year. She is twenty five, single and has no children. She was covered under her parents' plan until she graduated from college. After that, she carried in individual plan with a $100 deductible and even some prescription coverage. Although she never filed a claim, her premiums started going up and she gradually increased her deductible to $1,000 and dropped all coverage except major medical and hospitalization. When the premiums reached $2,400 per year, she dropped the coverage and now has no insurance. She works two part-time jobs making about $8.00 per hour. She values the protection of insurance even though the only claim ever paid was to have her appendix removed when she was ten years old.

Uninsured Healthcare - Individual Experiences

- Man in his mid 60s is disabled making about $750 per month from Social Security, he cannot afford his prescription drugs, and as an alternative lays down to alleviate abdominal pain. He attempted to get treated at the local hospital emergency room for diagnostic services, but was then referred to a large public teaching hospital in the city for a CT scan. After 36 hours, the hospital informed him that since he was not a resident within the county that supports the hospital, the hospital was unable to provide treatment. The patient was sent back home.
- A white, middle aged man in his 50s is self-employed or he works for a small company and cannot afford to carry personal health insurance, his wife has severe spinal problems and needs surgery, but the orthopedic specialist wants $30,000 payable in advance. She is unable to receive treatment.
- A single mother in her early 40s with children works for McDonald's and is on their insurance plan. She has to accrue $300 dollars for prescriptions before being reimbursed, and she only gets a small percentage of medical bills paid by insurance plan.

Uninsured Healthcare - Individual Experiences

- Woman in her late 40s to early 50s explained that her public health coverage forced her to get her drugs at the beginning of the month. If something happened to her medically towards the end of the month, she would have to wait until the first of the next month to go seek treatment in order to get some assistance from her public insurance.
- Female in her mid 20s works for a temporary agency, but does not receive any health insurance benefits. She will not go to the free clinic for healthcare due to the low quality of care that is provided.
- Female in her mid 40s, she has worked for many temp agencies who assigned her to small manufacturers making $6 per hour. She is not interested in health insurance unless it is a few dollars per month.

Summary Responses by Stakeholder

Summary Response - Uninsured (1 of 2)

- **On coverage**
  - Increasingly being dropped by employers
  - If offered by employer, very likely not to be taken by employee due to its high cost
  - Large companies can afford, small businesses cannot
  - Temporary and part-time workers are ineligible to qualify to purchase
  - Preexisting conditions prevents many from qualifying
- **On costs**
  - Unaffordable by small business employers and employees
- **On consequences**
  - High cost discourages the use of medical care
  - Providers demand payment in advance; high cost specialty procedures are unaffordable, and hence not performed
  - Fear of bankruptcy and/or damage to credit record discourages utilization
  - Access to physicians is very difficult, appointments are difficult to obtain
- **On a "Basic Plan" and how much to pay?**
  - Rx drugs, MD visits, hospitalizations, vision, dental, preventative and diagnostic screenings
  - How much? – between $10-$200 per month per individual based on income level

Summary Response - Uninsured (2 of 2)

- **On where to go for care, who pays, and what are the implications?**
  - Free care/Free clinics - where available
  - ER
- **On the recent health care experience**
  - Access to physician offices is greatly enhanced with insurance
  - Attitude of staff improves when one has insurance
- **On government programs and the Medicaid program in particular**
  - Awareness of programs varies by county
  - Generally, program information is poorly communicated or coordinated among existing infrastructure (with exceptions)
  - Hoosier Healthwise – rave reviews
  - Medicaid – eligibility is difficult, complex process/system of qualification very few understand, long waiting periods, lots of paperwork, and relatively rich benefit package creates disincentives to leave program

Summary Response
Physician Providers (1 of 2)

- **On the uninsured**
  - Who are they? unemployed, minimum wage, small businesses, immigrants
  - Challenges they face: access to MDs, bankruptcies on increase, ERs are overcrowded, Rx drugs are unaffordable
- **On coverage**
  - It exists – need to motivate individuals to purchase or participate
  - Too costly for employers and employees
  - Not a priority purchase for many to make
- **On where to go for care, who pays, and what are the implications?**
  - ER, free clinics
  - Free clinics are being utilized more, but ER load is not decreasing
- **What should a state sponsor "Basic" health plan cover?**
  - Emergency care, Rx drugs, physician care, mental health, health screenings, and other preventative care to relieve the ER demand
- **On government and the Medicaid program in particular**
  - Less government involvement is better
  - Care rationing is needed
  - Need more preventative care
  - Too many MDs do not accept Medicaid patients
  - Medicaid is currently too expensive to operate – too many man hours required, provider reimbursements are too low, paperwork is a hassle, auditing is too costly to endure, and the first dollar coverage incentivizes inappropriate utilization
  - HIPAA paperwork is excessive
  - Public does not want more programs until they are in need
  - Government needs to mandate insurance coverage, maintain low bureaucracy

Summary Response
Physician Providers (2 of 2)

- **On responsibility for coverage and recommendations for the future**
  - Government mandated, co-pays, premiums/co-pays based on income
  - Need to educate families on importance of preventative care
  - A state-sponsored minimal insurance program covering primary and preventative care on a pay-as-you-go basis
  - Government programs are not acceptable by public until they are in need
- **Other comments**
  - Nurses now spend 35% of their time on non patient issues (i.e., paperwork)
  - Pool of volunteer MDs for free clinics would increase if malpractice/liability insurance was provided by the state
  - Tort reform, incentivize primary care, ability to cost shift to private sector is a key reason for Medicare

Summary Responses
Community Groups (1 of 2)

- **On coverage**
  - Employer based
  - Lack of coverage exacerbated by poor economy
  - People without insurance get coverage via Medicare and Medicaid
  - Hospital write-offs are growing
  - Pre-existing conditions are the major obstacle to qualifying for coverage
  - 25% do not have insurance, 50% have insurance, 25% on Medicaid (Kokomo)
  - Certain cultural beliefs are obstacles to care (Example: Hispanics and pregnancy)
- **On costs**
  - Premiums are generally affordable – co-pays and deductibles are the problem
  - Premiums are outpacing wages
- **On consequences**
  - Employers moving to HMOs or dropping coverage altogether
  - Poor access to specialists
  - Preventative care is elusive
  - Fear of financial losses and/or receiving bad credit hinders appropriate utilization
- **Who are uninsured?**
  - Part-time and the unemployed
  - Those who lack coverage are in "low end" jobs (retail, hotel, restaurants, seasonal)
- **Why are they uninsured?**
  - Coverage relatively unimportant to most people
- **On a "Basic Plan" and how much to pay?**
  - Preventative care, immunizations, basic dental, mental health, prenatal care
  - How much ? – between $100-$200 month with reasonable co-pays

Summary Responses
Community Groups (2 of 2)

- **On where to go for care, who pays, and what are the implications?**
  - ER, free clinic, community health center
  - Sliding scale clinic is good but overcrowded and prescriptions are difficult to obtain
- **On government programs and the Medicaid program in particular**
  - Awareness varies by location (very good to very poor), external communications program is lacking, communication is word of mouth
  - Many do not know how to access government programs
  - Pride and stigma of public programs hinders participation
  - Medicaid – complex program, lots of paperwork, eligibility decisions take too long (six months), CHIP and Hoosier Healthwise are successful, does not cover enough people – just the very poor, provider network is too small , many do not understand the program
- **On responsibility for coverage and recommendations for the future**
  - Government – but it changes too much
  - Employers
  - State basic health program – with premiums based on sliding scale according to income, easy access to physician, expand eligibility to include those trying to work, needs extensive publication, preventative care model, need to re-define disability, exchange coverage for volunteer work, administer the program through local clinics.

Summary Responses
Insurance Brokers (1 of 3)

- **Why do small businesses offer coverage?**
  - Attract and retain employees, social expectations
  - Owner wants coverage for self and spouse
  - Tax deductibility
- **Recent rate increases (Past three years)**
  - 15-30% for simple plans
  - 75-100% for other plans with high risks (i.e., cancer cases, etc.)
  - HIPAA responsible for some of the increase
  - Individual risks can raise rates 100% or more (need verify)
- **Key attributes of offering coverage to an employer**
  - Cost, cost, cost
  - Scope of provider network
  - Service in administering claims
  - Reputation of carrier
  - Policy waiting periods
  - Once the above are met, then commission level and whether carrier can guarantee premium for at least one year
- **Size of business more likely to offer coverage**
  - Between 11-50 employees
  - Older more established businesses
  - If less than five employees – likely not to offer coverage
  - Many "Mom and Pop" businesses offer (less than 10 employees), but employees do not accept due to high cost
- **Types of business <u>more likely</u> to offer coverage**
  - Auto parts, union shops, white collar, 12-month employees (not seasonal)
- **Types of businesses <u>less likely</u> to offer coverage**
  - Steelmakers, small manufacturers, tool and die makers, service businesses (gas stations), seasonal or those businesses with high turnover (retail, restaurants, and hotels)

Summary Responses
Insurance Brokers (2 of 3)

- **Strategies used to lower premium costs**
  - Raise deductibles and co-pays (i.e., cost shift to the employee), spousal exclusions, fixed level of contributions from employer, health reimbursement accounts, eliminate dependent coverage, encourage to join spouse's plan, drop dental and vision coverage, disease management initiatives, eliminate short-term disability coverage, employee education
- **Other factors**
  - Level of paperwork due to HIPAA
  - Willingness of employers to commit to 25% average annual premium increases
  - Agent service levels to provide necessary education to employees about their benefits
  - Disease exclusions only apply to employers with over 50 employees
  - Stated level of employer's contribution not audited – how much are premiums subsidized?
  - 30 hours per week threshold before coverage is mandated
- **On responsibility for coverage and recommendations for the future**
  - State needs to offer incentives for people to buy insurance
  - Reinstitute waivers for individual insurance market
  - Eliminate mandated coverage for group market
  - State sponsored education to inform people of their options (i.e., affordable MSAs with high deductibles)
  - Need ability to decrease level of benefits to lower the cost
  - Expand defined contribution programs
  - Offer MSAs with high deductible catastrophic care policy
  - Offer individual tax credits for purchasing coverage

Summary Responses
Insurance Brokers (2 of 3)

- Fix ICHIA – limit lifetime maximums in line with commercial insurers ($2-$3 million) and eliminate the three month premium paid in advance to enroll because many qualified people cannot afford
- Allow exclusions for some individuals in small groups in order to lower premiums for small businesses
- State-subsidized insurance is bad idea, as government should not be involved in the healthcare purchase
- Keep incentives aligned – so that people will want to work to expand their benefit package

- **Other comments**
  - Brokers = coverage is a privilege
  - Employees = coverage is a right

Summary Responses
Small Businesses (1 of 2)

- **Why offer coverage?**
  - Employee retention and attraction
  - Tax deductibility of premiums
- **Recent rate increases (Past three years)**
  - Between 20-50% with some at 75-100%
- **Strategies used to keep costs down**
  - Implement Medical Savings Accounts (MSAs) combined with catastrophic coverage with high deductible
  - Scale back benefits
  - Raise deductibles, co-pays
  - Pay cash directly to employees ("under the table")
  - Extensive education to employees on true cost of coverage
  - Join Professional Employment Organizations (PEOs)
  - Change carriers frequently
  - Purchase insurance through a larger group association
- **What level of premium would prompt you to withdraw coverage altogether?**
  - Question arises each year
  - Target number is rapidly approaching as profits decline and premiums increase
  - Very dependent upon local economic conditions
  - Current premium

Summary Responses
Small Businesses (2 of 2)

- **Recommendations to increase coverage for employees**
  - Employer tax credits prorated based on the level of employer's contribution
  - Move employer-based insurance model back to where it began - catastrophic care only
  - More information needed on the costs/value of different healthcare providers
- **What should the government's role be (if any) to increase healthcare coverage**
  - Keep government out of the health insurance marketplace
  - Help to better inform employers and consumers of provider costs
  - Educate employees that healthcare is not an entitlement
  - Mandate insurance companies inform employees of state programs, if eligible
  - Increase awareness of public programs
  - Need to revamp ICHIA funding formula and eligibility criteria for high risk individuals – currently serves too many out of state residents
  - Ensure neighborhood clinics are in place for the uninsured

Any questions???